

# MODERN MEDICO-LEGAL TRENDS

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## INTRODUCTION

The present day medical center bears little resemblance to the hospitals of the early part of this century when they were thought of merely in terms of providing facilities where patients could meet professional people with a view to undergoing surgery or receiving general nursing care. Advances in medical science have made it necessary for the physicians to call upon the hospital for an increasing variety of services, some of which involve exceedingly complex procedures requiring highly specialized skills.

In response to this demand, the hospitals have evolved certain organizational patterns which function in such a manner as to make needed skills and services available to the patient in an efficient program of patient care. As a result, the modern hospitals have greatly increased in both size and efficiency, and an unfortunate consequence of this has been the decreased opportunity for the old-fashioned personal human relationship between physician and patient. This relationship still remains the most important ingredient of medical practice. Frequently, actions against a doctor or hospital have their origin in some fancied personal slight or some appearance of neglect, often based on nothing more than a lack of courtesy or consideration on the part of members of the hospital staff. When the physician-patient relationship is good, there is far less likelihood of misunderstandings and much less chance of medical people becoming involved in actions for negligence.

Medical malpractice lawsuits are increasing at an alarming rate in both England and the United States. Malpractice insurance fails to eliminate the punitive effects of an adverse judgment since it cannot protect the doctor against the inevitable damage to his professional standing in the community. In fact, all physicians are injured to some degree by every publicized malpractice claim.

During the past twenty years, the public has become increasingly aware of the possibilities of financial gain which may accrue to them if by chance some harm has resulted from their medical or surgical treatment. Many malpractice claims rest on no better foundation than some disappointment in the outcome of therapy

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and the hope that somehow the mishap may be turned into a profit. Most of the claims for negligence arise out of treatment in hospitals where the patients' needs are served by an endless variety of domestic, technical, paramedical, general, and specialized medical personnel, sometimes acting individually and sometimes as members of a highly integrated team.

With improvements in the technique and advances in the knowledge of modern anesthesia, development of the heart pump, and the use of other resuscitative measures, operations can now be attempted where formerly no attempt was feasible. Many of these new operations are inherently dangerous in themselves and often involve methods which present their own special risks. Their complexity has greatly increased the opportunities for error by the surgeon or anesthesiologist. In attempting such operations as replacing damaged and inefficient heart valves, which threaten the life of the patient; closure or repair of cardiac defects in babies and young children; or transplanting healthy kidneys in patients dying of renal failure, doctors have added many useful years to their lives. Must they also support some of them financially for all those added years of survival? Certainly any threat to the integrity of these hospitals and dedicated medical people is a matter of grave public concern.

It is so easy to be wise after the event and to condemn as negligence that which was only a misadventure. We ought always to be on guard against it, especially in cases against hospitals and doctors. Medical science has conferred great benefits on mankind, but these benefits are attended by considerable risks. . . . We cannot take the benefits without taking the risks. Every advance in technique is also attended by risks. Doctors, like the rest of us, have to learn by experience; and experience often teaches in a hard way. Something goes wrong and shows up a weakness, and then it is put right. That is just what happened here. Dr. Graham sought to escape the danger of infection by disinfecting the ampoule. In escaping that known danger he unfortunately ran into another danger. He did not know that there could be undetectable cracks, but it was not negligent for him not to know it at that time. We must not look at the 1947 accident with 1954 spectacles. . . .<sup>1</sup>

Indeed, it was the extraordinary accident to these two men which first disclosed the danger. Nowadays, it would be negligent not to realize the danger, but it was not then.

One final word. These two men have suffered such terrible consequences that there is a natural feeling that they should be compensated. But we should be doing a disservice to the community at large if we were to impose liability on hospitals and doctors for everything that happens to go wrong. Doctors would

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<sup>1</sup> *Roe v. Minister of Health*, [1954] 2 Q.B. 66, 83 (C.A.).

be led to think more of their own safety than of the good of their patients. Initiative would be stifled and confidence shaken. A proper sense of proportion requires us to have regard to the conditions in which hospitals and doctors have to work. We must insist on due care for the patient at every point, but we must not condemn as negligence that which is only a misadventure.<sup>2</sup>

There is some apprehension on the part of the medical profession, not without support in recent cases, that the courts are requiring a higher standard of due care than formerly. The courts in England, as well as in some American jurisdictions, have refused to continue the "community" test widely applied throughout most of the United States. This test prevented the application of a uniform standard of due care and afforded relief to the rural practitioner at a time when inadequate means of transportation and communication prevented him from keeping abreast of scientific progress.<sup>3</sup> There is little doubt that the quality of actual care has improved as a result of scientific advances and newly acquired knowledge.

Apparently there is a tendency to increase the duration of vulnerability of the medical profession to the threat of legal action. For example, the statute of limitation for medical malpractice in the state of Ohio is one year.<sup>4</sup> If, however, the negligent act was the proximate cause of the death of the patient, the two-year limitation of the wrongful death statute<sup>5</sup> comes into operation.<sup>6</sup> The action is brought by the personal representative of the decedent for the pecuniary loss resulting from his death. Though based on malpractice, it is a separate cause of action from that which the injured party would have had if he had survived.

Just three months after the decision, the Ohio Supreme Court, in a split decision, held that a husband's suit for medical expenses incurred and for loss of consortium and services of his wife, who was injured through medical negligence, was not one for malpractice and therefore not governed by the one-year statute of limitations.<sup>7</sup> The court said that the injury was to the rights of the plaintiff and was not one arising on contract or enumerated in the Revised Code and therefore fell within section 2305.09 (D),<sup>8</sup>

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<sup>2</sup> *Id.* at 86.

<sup>3</sup> See *Tvedt v. Haugen*, 70 N.D. 338, 294 N.W. 183 (1940); *Sinz v. Owens*, 33 Cal. 2d 749, 205 P.2d 3 (1949). See generally *McCoid*, "The Care Required of Medical Practitioners," 12 Vand. L. Rev. 549 (1959).

<sup>4</sup> Ohio Rev. Code Ann. § 2305.11 (Page 1954).

<sup>5</sup> Ohio Rev. Code Ann. § 2125.02 (Page 1954).

<sup>6</sup> See *Klema v. St. Elizabeth's Hosp. of Youngstown*, 170 Ohio St. 519, 166 N.E.2d 765 (1960).

<sup>7</sup> *Corpman v. Boyer*, 171 Ohio St. 233, 169 N.E.2d 14 (1960).

<sup>8</sup> Ohio Rev. Code Ann. § 2305.09 (D) (Page Supp. 1963).

which prescribes a four-year statute of limitations. This allows the plaintiff two years in addition to the Ohio general negligence statute in which to institute suit. The dissent argued that the cause of action is enumerated in other parts of the statute, and also, since the plaintiff must prove medical negligence to prevail, his case is one for malpractice.

The elasticity inherent in the one-year Ohio statute of limitations is readily demonstrated by a review of the cases in this and other states. In interpreting the legislative intent, the Ohio courts have held that the statute of limitations begins to run from the time when the physician-patient relationship has been terminated.<sup>9</sup> In California, Florida, Louisiana, Pennsylvania, Texas, and New Jersey, under statutes like the Ohio's, courts have held that the statute of limitations does not run until the discovery of the injury or until plaintiff should have discovered the injury. Judge Gibson, in the concurring opinion in the *Lundberg* case,<sup>10</sup> urges that it is unrealistic to say that the plaintiff had a cause of action all along even though he was unaware of it.<sup>11</sup> He suggests that there is no sound reasoning behind the present Ohio rule that the statute of limitations begins to run upon the termination of the physician-patient relationship and he favors the more equitable rule which would date the running of the statute from the time of discovery of the injury or from such time as the plaintiff, in the exercise of reasonable diligence, should have discovered the injury.

Other statute-of-limitations problems are involved in determining the class of persons to whom the one-year malpractice statute of limitations was intended to apply. Most courts have not distinguished between nurses and physicians in cases of medical malpractice. However, an early New York case<sup>12</sup> applied the three-year general negligence statute when a nurse was alleged to have been negligent, rather than the two-year statute of limitations for malpractice, on the ground that nursing was not the practice of medicine. In a suit against a hospital, the court held that the statute of limitations for malpractice was unavailable as a defense because a hospital could not lawfully practice medicine and there-

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<sup>9</sup> See, *e.g.*, *DeLong v. Campbell*, 157 Ohio St. 22, 104 N.E.2d 177 (1952); *Bowers v. Santee*, 99 Ohio St. 361, 124 N.E. 238 (1919); *Gillette v. Tucker*, 67 Ohio St. 106, 65 N.E. 865 (1902).

<sup>10</sup> *Lundberg v. Bay View Hosp.*, 175 Ohio St. 133, 191 N.E.2d 821 (1963).

<sup>11</sup> *Contra*, *Shearin v. Lloyd*, 246 N.C. 363, 98 S.E.2d 508 (1957). This court, in a "missing sponge" case, held that the statute of limitations began to run at the time that the negligent act occurred.

<sup>12</sup> *Isenstein v. Malcomson*, 227 App. Div. 66, 236 N.Y. Supp. 641 (1929).

fore could not be liable for malpractice, but only for negligence.<sup>13</sup> In 1962, however, in *Flynn v. New York Hosp.*,<sup>14</sup> the court assumed that the defense would be available to the hospital.

Another facet of the statute of limitations problem is presented in the *Lundberg* decision.<sup>15</sup> In this case a patient sued the hospital, alleging that the negligence of its physician-pathologist, a salaried employee, in making a careless and faulty diagnosis of cancer in a biopsy specimen, caused her to undergo unnecessary surgery which incapacitated her. The pathology reports were made under the name of the hospital, and the patient was billed for these services by the hospital in April, 1955. Major surgery was performed on April 29, 1955, and the patient was discharged from the hospital on May 6, 1955. She continued to return to the hospital for routine check-ups until February 18, 1956. Suit was filed on February 16, 1957, almost two years after the pathology report was made. There was no evidence to show that she had any contact with the physician-pathologist after April, 1955, although apparently other members of the hospital's osteopathic staff continued to follow her progress for almost another year. The court said that the relationship continued until terminated with respect to the medical service "undertaken by the hospital" for the particular condition of the patient. The court went on to say:

The present action is essentially one for the recovery of damages for bodily injury due to negligence, and Section 2305.10, Revised Code, places a limitation of two years on the bringing of such an action. Thus, whether the action is treated as one for malpractice or as one for ordinary negligence, it was timely brought in either instance.<sup>16</sup>

This decision raises some very troublesome problems, some of which are illuminated in the concurring opinion of Judge Gibson:

I concur in the judgment on the basis that the hospital, a corporation, may not lawfully engage in the practice of medicine or osteopathy. . . . [I]ndividuals only may be licensed to engage in the practice of medicine or osteopathy. . . . It is to be presumed, in the absence of a claim and evidence to the contrary, that this hospital was not unlawfully practicing medicine or osteopathy. Hence, notwithstanding the fact that the cause has been treated by the parties and the lower courts as one in malpractice, the action, having been commenced . . . within two years after the

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<sup>13</sup> *Roewekamp v. New York Post Graduate Medical School & Hosp.*, 254 App. Div. 265, 4 N.Y.S.2d 751 (1938).

<sup>14</sup> 33 Misc. 2d 393, 224 N.Y.S.2d 881 (1962). See also *Davis v. Eubanks*, 83 Ohio L. Abs. 28, 167 N.E.2d 386 (1960).

<sup>15</sup> *Lundberg v. Bay View Hosp.*, note 10 *supra*.

<sup>16</sup> *Id.* at 136, 191 N.E.2d at 823.

negligent reading of the biopsy slide . . . , is not barred by Section 2305.10, Revised Code.

In my opinion, it is unnecessary for the court to discuss the statute of limitations regarding malpractice.<sup>17</sup>

Thus the negligence is treated as a corporate defect, and apparently the plaintiff need have no regard as to whether it is the physician-pathologist, the pharmacist, the nurse, or a member of the lay staff who is negligent, if this view is to be followed in the future.

However, the majority opinion discusses a new concept, the hospital-patient relationship, and approves the notion of "medical service undertaken by the hospital."<sup>18</sup> Can this be fairly interpreted as a de facto recognition of the corporate practice of medicine? The nature of a hospital-patient relationship is not at all clear. Judge Gibson goes on to say: "[T]here is no justification for extending the doctrine of *DeLong v. Campbell* . . . beyond the relationship of physician and patient to the relationship of hospital and patient."<sup>19</sup>

It would seem that the hospital is within the class intended to be protected by the legislature in enacting a statute of limitations for malpractice actions. It is certainly a valid defense when asserted by the physician who is primarily negligent.<sup>20</sup> Should it not also be available to the hospital who is only secondarily negligent by virtue of being the employer of the tortfeasor?

### RES IPSA LOQUITUR

There is no place in the field of medical malpractice for the doctrine of *res ipsa loquitur*. In the *Roe* case, Lord Justice Morris said of it: "[T]his convenient and succinct formula possesses no magic qualities: nor has it any added virtue, other than that of brevity, merely because it is expressed in Latin."<sup>21</sup> But he was wrong, for it does possess magic qualities. Originating in the incident of the falling barrel and apparently incompletely understood, each appearance of that doctrine in the courts has resulted in some alteration of the original concept so that by 1964, it has emerged as an instrument of social justice and not as a rule of law. *Res ipsa loquitur* means "the thing speaks for itself." But *what* does it say?

<sup>17</sup> *Id.* at 136, 191 N.E.2d at 824.

<sup>18</sup> *Id.* at 135, 191 N.E.2d at 823.

<sup>19</sup> *Id.* at 137, 191 N.E.2d at 824.

<sup>20</sup> See *Klema v. St. Elizabeth's Hosp. of Youngstown*, *supra* note 6, at 521, 166 N.E.2d at 767, where Judge Bell stated: "Had plaintiff's decedent survived the post-operative period and brought suit himself against the negligent doctor, no serious contention could be made that any other than the one-year statute of limitations would have applied."

<sup>21</sup> *Roe v. Minister of Health*, [1954] 2 Q.B. 66, 87 (C.A.).

In some of the most recent cases it seems to be saying that courts are applying a new legal basis for therapeutic misadventure: *i.e.*, liability without fault. *Res ipsa loquitur* has been described as "a common sense appraisal of the probative value of circumstantial evidence."<sup>22</sup> The difficulty in relying on common sense, however, is that it is so uncommonly found.

The first requirement for the application of the doctrine is that the accident be of a sort that does not ordinarily occur unless someone is negligent. As to this element of the triad, one court has said that *res ipsa loquitur* is applicable in malpractice cases:

only . . . where a layman is able to say as a matter of common knowledge and experience that the consequences of professional treatment were not such as ordinarily would have followed if due care had been exercised.<sup>23</sup>

Here a child had died while undergoing a tonsillectomy under general anesthesia. Whereas a tonsillectomy may be considered minor surgery, the administration of a general anesthetic is always a major procedure, attended by considerable risk. The possibility of a fatal outcome is always present even though the greatest possible degree of skill and care be used. Anesthesia for tonsillectomy is much more hazardous than that given for many other procedures, for the operative field is within the patient's airway. That a layman could conclude that an anesthetic death does not occur in the absence of negligence is sheer nonsense.

As Judge Traynor correctly pointed out in his dissent:

[B]y approving the instruction, the court in effect holds that solely because an accident is rare it was more probably than not caused by negligence. There is a fatal hiatus in such reasoning. The fact that an accident is rare establishes only that the possible causes seldom occur. It sheds no light on the question of which of the possible causes is the more probable when an accident does happen.<sup>24</sup>

The second prerequisite to invoking the doctrine is that the accident be caused by an instrumentality within the exclusive control of the defendant. Even in the most obvious "missing sponge" cases, which meet the first requirement of *res ipsa loquitur*, there is no such thing as the instrumentality being within the *exclusive control* of the defendant. A minimum of three persons, and more

<sup>22</sup> Frost v. Des Moines Still College of Osteopathy & Surgery, 248 Iowa 294, 301, 79 N.W.2d 306, 311 (1957).

<sup>23</sup> Cavero v. Franklin Gen. Benevolent Soc'y, 36 Cal. 2d 301, 309, 223 P.2d 471, 476 (1950).

<sup>24</sup> *Id.* at 314, 223 P.2d at 479.

commonly a team of four or five, share the control of the instrumentality. In *Ybarra v. Spangard*,<sup>25</sup> where there were multiple defendants, this troublesome requirement was promptly changed, and "exclusive control" of "the" defendant was no longer a *sine qua non*.

The third requirement presents little difficulty. It is the familiar rule that the plaintiff must not have been contributorily negligent.

*Res ipsa loquitur* has been said to give rise to an inference of negligence which would require the defendant to come forward with evidence to explain how a particular accident could have happened even though due care was exercised. If this were done, the inference would disappear, and the burden would be on the plaintiff to present evidence showing that the defendant was negligent. This also is apparently no longer true. Courts sometimes ignore the basic rule that the evidence must sustain the inference of negligence against a particular defendant. In the case of *Cho v. Kempler*<sup>26</sup> the California court, in spite of the fact that there was no proof of malpractice and in spite of the fact that the defendant gave an adequate explanation of the mishap, permitted the jury to consider the case on the theory of *res ipsa loquitur*. This procedure has been criticized by Professor Jaffe of the Harvard Law School:

[I]f the defendant's explanation is not to be accepted, the doctrine of *res ipsa* should not be applied at all. It is something of a mockery to require the defendant in the name of fairness to offer an explanation and then let a jury ignore the explanation on no other basis than its choice not to believe.<sup>27</sup>

The *Cho* case was concerned with a facial paralysis following severance of the seventh nerve during a radical mastoidectomy. The medical testimony showed that this was a rare complication of such an operation but that it can occur in the absence of negligence. Cases based on the same medical facts have been decided in Tennessee<sup>28</sup> and in Maryland.<sup>29</sup> In both, the courts correctly rejected the application of *res ipsa loquitur*, since the injuries could have occurred regardless of the care used. In 1962, a California court properly rejected the doctrine in a case of dehiscence following an operation for resection of the sigmoid colon.<sup>30</sup> The court realized that it was not a matter of common knowledge that a de-

<sup>25</sup> 93 Cal. App. 2d 43, 154 P.2d 687 (1944).

<sup>26</sup> 177 Cal. App. 2d 342, 2 Cal. Repr. 167 (1960).

<sup>27</sup> Jaffe, "Res Ipsa Loquitur," 1 Buffalo L. Rev. 1, 11 (1951).

<sup>28</sup> Calhoun v. Fraser, 23 Tenn. App. 54, 126 S.W.2d 381 (1938).

<sup>29</sup> Bettigole v. Diener, 210 Md. 537, 124 A.2d 265 (1956).

<sup>30</sup> Jamison v. Debenham, 203 Cal. App. 2d 744, 21 Cal. Repr. 848 (1962).



hiscence will not occur unless there is negligence, or that a scultetus binder would prevent its occurrence, and therefore, failure to put on such a binder does not make *res ipsa loquitur* applicable. Whether this case heralds a reversal in the trend in California must await future developments. The improper use of *res ipsa loquitur* in medical malpractice cases is sometimes explained as a response of the courts to the relative inability of the plaintiff to determine what happened while he was undergoing medical, and especially surgical, treatment and his inability to obtain expert witnesses to help him establish the requisite proof of negligence in the court room.

The first basis advanced as justification of this practice is completely without merit. Under the modern rules of civil procedure, by means of deposition and other discovery procedures, all of the medical and hospital records, as well as the explanation of the involved parties, are available to the plaintiff. For instance, the patient's medical chart has included within it the operating room sheet containing the names of all the operating room personnel and the capacity in which they served the needs of the patient; the number and type of sponges used during the surgery and the signature of the nurse responsible for making a correct sponge count; and description of the operation as dictated by the surgeon, including all pertinent steps of the procedure, as well as an infinite amount of other medical data observed and accurately recorded by the hospital staff, are included therein.

There is some merit in the contention that doctors are reluctant to testify in court. Doctors are busy people, and they regard with serious concern every request to make a courtroom appearance on behalf of clients, whether in the everyday variety of personal injury claims or in the comparatively rare malpractice cases. As expert witnesses they go to court prepared to render an opinion on subjects within their expertise. All too frequently, they are never permitted to express their "expert opinion." Modern trial tactics make it imperative for opposing counsel to permit them to say or imply just enough to influence the jury in drawing a particular inference. Then, on cross examination, the doctor is frequently made to feel as if he were the defendant in a major criminal trial and not, as he hoped, an expert witness performing a civic duty by assisting the court to reach a just decision. A doctor understandably does not relish the prospect of facing opposing counsel's efforts to discredit him as person before the jury. Despite this natural reluctance to function other than as a physician, many physicians are willing to testify in a meritorious cause. Evidence of this is seen in the joint medico-legal plan for screening medical

malpractice cases established by the Joint Medico-Legal Committee of the New Mexico Medical Society and the New Mexico State Bar Association.

A final comment on the doctrine of *res ipsa* might well focus on the notion that it results in "a common sense appraisal of the probative value of circumstantial evidence."<sup>31</sup> This vague approach would make everything depend upon whether an ordinary person would deem as negligent a given act. Such common sense tests "have a way of collapsing in marginal cases and of leading to a maze of casuistry without much principle."<sup>32</sup> Two similar 1953 cases illustrate this point. Plaintiffs in Kansas<sup>33</sup> and North Carolina<sup>34</sup> brought suits for damages for X-ray burns suffered while undergoing X-ray therapy for the removal of warts. The Kansas court accepted the argument that *res ipsa loquitur* was applicable because the defendant had examined plaintiff's wart, advised its removal, assumed the duty of removing it in a proper manner, and had exclusive control of the X-ray equipment, and yet plaintiff had suffered severe burns.<sup>35</sup> The North Carolina court, however, ruled that the doctrine was inapplicable, as the X-ray burns could have occurred even if proper care had been exercised.<sup>36</sup> It is arguable that the results in these two cases are inconsistent, and it would seem that such an inconsistency vitiates the notion of a "common sense appraisal" of circumstantial evidence, at least in regard to the problems involved in medical malpractice suits.

In a recent case, the Ohio Supreme Court affirmed a lower court ruling which permitted a nurse acting in her professional capacity to be found negligent without requiring expert testimony at the trial.<sup>37</sup> The majority held that:

The court may take judicial notice that juries of today include women. Many of these woman jurors are mothers and, in many instances, grandmothers. In the case at bar, there were six women. They know probably as much if not more about childbirth than many experts who might be put on the witness stand.<sup>38</sup>

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<sup>31</sup> Frost v. Des Moines Still College of Osteopathy and Surgery, note 22 *supra*.

<sup>32</sup> Kahn-Freund, "Servants And Independent Contractors," 14 Modern L. Rev. 504, 507 (1951).

<sup>33</sup> Emrie v. Tice, 174 Kan. 739, 258 P.2d 332 (1953).

<sup>34</sup> Nance v. Hitch, 238 N.C. 1, 76 S.E.2d 461 (1953).

<sup>35</sup> See *supra* note 33, at 745, 258 P.2d at 338.

<sup>36</sup> See *supra* note 34, at 13, 76 S.E.2d at 469.

<sup>37</sup> Jones v. Hawkes Hosp. of Mt. Carmel, 175 Ohio St. 503, 196 N.E.2d 592 (1964).

<sup>38</sup> *Id.* at 507, 196 N.E.2d at 595.

These profound observations were aptly answered by Judge Duffey in a well-reasoned dissenting opinion:

I fail to see how the majority opinion is strengthened by the fact that some jurors are women (apparently as opposed to men), some of whom the majority assumes to be mothers and whom the majority further assumes to know more about childbirth than "many experts." This case involves the conduct of a nurse and not childbirth. It is true that the appellant here (as any plaintiff in a malpractice action) had difficulty producing evidence, both because of the lack of witnesses at the crucial point in this case as well as the professional aspects of the action. However, the difficulty of obtaining evidence is not a substitute for a lack of evidence.

The type of case has, and should have, bearing on how strictly the evidence is viewed. Malpractice has been traditionally distinct from other negligence actions. The distinction lies not just in analytical differences but in recognizing the human factor that patients and jurors tend to expect too much. We tend to fail to distinguish a professional's mistake in judgment from unreasonable judgment. Anticipating excellence, we condemn in hindsight anything short of perfection. Failure becomes proof of incompetence. The law of malpractice has partially controlled this by a stricter application of the rules of evidence and by emphasis in instructions. There are many who believe that these controls have been eroded in recent years—that with the advance in medicine the judiciary too is now demanding perfection.<sup>39</sup>

### HOSPITAL LIABILITY

On no part of the community has the impact of the Welfare State been so striking as on the hospitals and on medical practice generally. On the hospitals more than on general practice because, from being voluntary organizations maintained in part by charitable contributions, in part by fees paid by patients, and in very great part by honorary service given by generations of surgeons and physicians, the hospitals are now quite changed.

. . . No longer are medical services given in public hospitals as a charitable act. Staffs, whether professional or otherwise, are paid; and the hospitals are, by right, free to all who seek treatment there.

This change in the constitution and management of hospitals has been marked by changes in the law not only in regard to the way in which the hospitals are maintained and governed and controlled, but in regard to the implications that may arise from allegations of negligence arising from treatment in such institutions.<sup>40</sup>

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<sup>39</sup> *Id.* at 511, 196 N.E.2d at 598.

<sup>40</sup> Lynch, "The Hospital, The Public, And The Law," 30 N.Z.L.J. 118 (1954).

In a series of cases, beginning in 1942 with the case of *Gold v. Essex County Council*,<sup>41</sup> hospital liability has been continually expanded. At that time, hospitals were liable only for negligent "administrative" acts of their employees, but the court soon abandoned the administrative-medical distinction and held that a hospital was liable for the negligent acts of a nurse unless she was found to be the "borrowed servant" of the physician. *Collins v. Hertfordshire County Council*<sup>42</sup> carried the trend still further. The hospital was held liable for the negligence of a resident physician who prepared a solution of one per cent cocaine instead of one per cent procaine in response to a telephone order. Finally, the case of *Cassidy v. Ministry of Health*<sup>43</sup> is considered by many authorities to be the leading case in establishing the modern theory of hospital liability. Here, the hospital was held liable for the negligent acts of its employees, whether nurses or doctors. The limitations of vicarious liability of the hospital were considered to coincide with those of the contract of employment.

Kahn-Freund suggested that his decision was based on a transformation of the traditional "right to control" test into something like the "subordination" test or "organizational" test operative in France and Germany. He maintained that the control test had to be transformed if it was to remain a working rule and not a mere verbal incantation.<sup>44</sup>

The tremendous scientific, technical, and economic developments which are a concomitant of our era have wrought changes in the relationship of master and servant and employer and employee. *Respondeat superior* has commonly been applied throughout industry, even though the employer was totally ignorant of the scientific details or technical methods which must be employed in doing some of the more complicated tasks. To say that such an employer "controls" the performance is unrealistic. Such employees are hired precisely because they have the specialized knowledge, skill, and judgment that these jobs require. The employer retains ultimate control by virtue of his power of dismissal. This applies just as well to the physician-employee as it does to the technician. Subordination to the employer's managerial power is made the test.<sup>45</sup>

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<sup>41</sup> [1942] 2 K.B. 293 (C.A.).

<sup>42</sup> [1947] K.B. 598.

<sup>43</sup> [1951] 2 K.B. 343 (C.A.).

<sup>44</sup> See Kahn-Freund, "Servants And Independent Contractors," 14 Modern L. Rev. 504.

<sup>45</sup> See *Mersey Docks & Harbour Bd. v. Coggins & Griffiths (Liverpool) Ltd.*, [1947] A.C. 1.

Integration into the employer's organization is the essential ingredient. Doctors and nurses are considered to be a part of the organization of the hospital for implementing the treatment of the patient. This emphasis on the hospital's organizational responsibility was clearly reflected in *Jones v. Manchester Corp.*,<sup>46</sup> in which a newly qualified doctor was required by the hospital rules to administer anesthetics in the hospital's emergency room. Mr. Justice Oliver said:

I think to put a weapon like a barbituric within reach of a girl who has only been qualified for five months and expect her to handle it accurately, with sufficient knowledge and experience—to watch the way a patient has to be watched—is simply asking for trouble.<sup>47</sup>

Although both the doctor and the hospital were held to be primarily negligent, a more serious view was taken of the hospital's failure to so run its organization that such a mistake would not occur.

In the *Roe* case, Lord Justice Denning, who wrote a concurring opinion, would have expanded a hospital's liability for its staff still further:

[T]he hospital authorities are responsible for the whole of their staff, not only for the nurses and doctors, but also for the anaesthetists and the surgeons. It does not matter whether they are permanent or temporary, resident or visiting, whole-time or part-time. The hospital authorities are responsible for all of them. The reason is because, even if they are not servants, they are the agents of the hospital to give treatment. The only exception is the case of consultants or anaesthetists selected and employed by the patient himself.<sup>48</sup>

Hospital liability is founded at present on its relationship to the negligent person. However, it could be founded on the obligation taken by the hospital toward the patient, and Lord Justice Denning apparently favors this view. He has made the hospital analogous to a common carrier and applied the principle that when a person is under a liability to use care, he cannot relieve himself of such liability by employing an independent contractor. This imposition of a "personal" duty would, of course, provide an even wider basis of liability than either the "control" or "organizational" tests, but it would also put an impossible burden upon the hospital's staff. It would most certainly adversely affect the quality of medi-

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<sup>46</sup> [1952] 2 Q.B. 852 (C.A.).

<sup>47</sup> *Id.* at 854.

<sup>48</sup> *Roe v. Minister of Health*, [1954] 2 Q.B. 66, 82 (C.A.).

cal care, since no one knows better than the doctor that he cannot guarantee a good result.

The trend toward a wider basis of hospital liability is also readily observable in the United States. The trend has not been uniform, and a great deal of variety is to be found when viewed on a state-by-state basis. In some jurisdictions, hospitals are immune from lawsuits. In others, they are liable only if negligent in the selection of employees. Other states impose partial tort liability for paying patients but not for charity patients. In some jurisdictions, liability is determined on the nature of the negligent act performed, with the hospitals liable for ministerial or administrative acts but not for medical or professional acts requiring medical judgment and skill. On the other hand, some hospitals are considered to function as a governmental adjunct and claim immunity from suit on the theory of sovereign immunity.

With these many variations in mind, one might briefly consider some of the landmark cases which appear to punctuate the trend toward full liability for the hospital's staff. In *President & Directors of Georgetown College v. Hughes*,<sup>49</sup> Judge Rutledge pointed out the inequitable basis of hospital immunity when the patient's relationship to the hospital was the determinative factor:

Abolition of the immunity as to the paying patient is justified as the last short step but one to extinction. Retention for the nonpaying patient is the least defensible and most unfortunate of the distinction's refinements. He, least of all, is able to bear the burden. More than all others, he has no choice. He is the last person the donor would wish to go without indemnity. With everyone else protected, the additional burden of protecting him cannot break the trust. He should be the first to have reparation, not last and least among those who receive it.<sup>50</sup>

For many years the New York courts attempted to differentiate hospital liability on the basis of the nature of the act performed. If the act was considered administrative, the hospital was liable, whereas if it was medical or professional in nature, the hospital was not liable. These administrative-professional distinctions were evidence of a judicial policy of compromise between the normal application of *respondeat superior* and total immunity for charitable institutions. Hospital liability was gradually extended by a liberal interpretation of what constitutes an administrative task, and finally in 1957, the New York courts ruled that the hospital can be sued for the negligence of their employees acting

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<sup>49</sup> 130 F.2d 810 (D.C. Cir. 1942).

<sup>50</sup> *Id.* at 827.

within the scope of their employment.<sup>51</sup> There the courts overturned an old judge-made rule which had become unworkable:

The conception that the hospital does not undertake to treat the patient, does not undertake to act through its doctors and nurses, but undertakes instead simply to procure them to act upon their own responsibility, no longer reflects the fact. Present-day hospitals, as their manner of operation plainly demonstrates, do far more than furnish facilities for treatment. They regularly employ on a salary basis a large staff of physicians, nurses and internes, as well as administrative and manual workers, and they charge patients for medical care and treatment, collecting for such services, if necessary, by legal action. Certainly the person who avails himself of "hospital facilities" expects that the hospital will attempt to cure him, not that its nurses or other employees will act on their own responsibility.<sup>52</sup>

And further:

The rule of non-liability is out of tune with the life about us, at variance with modern day needs and with concepts of justice and fair dealing.<sup>53</sup>

There is discernible a trend toward complete abolition of hospital immunity, and in recent years judicial decisions have reflected this at an accelerating place.<sup>54</sup> When the allegedly negligent act is said to have been performed by a nurse, the courts generally discuss "right of control" in determining the applicability of *respondeat superior*. The trend appears to be toward rejection of the "borrowed servant" doctrine and holding liable the general employer, the hospital, except in certain special circumstances.<sup>55</sup> In most cases the torts of nurses and internes, in whom much less discretion is permitted, are more likely to be imputed to the hospital than those of the physicians, who possess greater skill. However, the status of the physician will ordinarily be determined by the facts of each case rather than his being arbitrarily classified solely on the basis of his profession. Considering the traditional "right of control" test, an increasing number of states, including California, Minnesota, Mississippi, New York, Ohio, Tennessee, and Wisconsin, have

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<sup>51</sup> See *Bing v. Thunig*, 2 N.Y.2d 656, 143 N.E.2d 3 (1957).

<sup>52</sup> *Id.* at 666, 143 N.E.2d at 8.

<sup>53</sup> *Id.* at 667, 143 N.E.2d at 9.

<sup>54</sup> See, e.g., *Avellone v. St. John's Hosp.*, 165 Ohio St. 467, 135 N.E.2d 410 (1956).

<sup>55</sup> See, e.g., *Rural Educational Ass'n v. Bush*, 42 Tenn. App. 34, 298 S.W.2d 761 (1957). In this "missing sponge" case, the court stated that it was the nurse's duty to count the sponges as a part of the hospital's service and required no special or professional skill or judgment of the surgeon.

partially or completely repudiated the view that a doctor can never be a servant. Physicians in residency training programs, although permitted by hospital rules and regulations to exercise a much greater degree of discretion than the newly qualified intern, have have often been found to be subject to the "right of control" of the hospital.<sup>56</sup>

The fully qualified physician or surgeon is usually, but not always, considered to be an independent contractor. In recent years, an increasing number of physicians have accepted salaried positions on hospital staffs, and some courts have considered them to be employees whose torts may be imputed to the hospital. However, the opinions are not always clear as to the basis upon which liability is founded. In the *Lundberg* case,<sup>57</sup> involving the negligence of a salaried physician-pathologist, the court found that he was an agent of the hospital by estoppel. "[T]he hospital by its conduct . . . induced the belief that [Dr.] Haws was in its employ as part of its regular establishment, whereby it was estopped to successfully claim otherwise."<sup>58</sup> In this case the patient was billed by the hospital for services rendered, and the pathology report was made under the heading of the hospital. These indicia of agency were found sufficient to hold the hospital liable under the doctrine of *respondeat superior*. Yet it is questionable that the requirements for invoking the doctrine of estoppel are present in this case. Where a principal by words or conduct causes another to believe in the existence of certain circumstances, and causes him to act in reliance upon that belief so as to change his previous position, he will be estopped to aver differently. Here the patient did not rely on the representations made by the hospital. These indicia of agency were unknown to her at the time the decision to perform the hysterectomy was made. Patients are not permitted to read the medical chart, and the patient would not have been billed until her discharge from the hospital the following month.

In *Seneris v. Haas*,<sup>59</sup> the physician-anesthesiologist, alleged to have been negligent in the administration of a spinal anesthetic, testified that he was an independent contractor who billed his patients directly on a fee-for-services basis. Yet it was held that he was an agent of the hospital, although the court was somewhat obscure as to the legal basis for liability. The traditional concept of "right to control" was not discussed. The court noted with approval the following argument: "An agency is ostensible when

<sup>56</sup> See, e.g., *Moeller v. Hauser*, 237 Minn. 368, 54 N.W.2d 639 (1952).

<sup>57</sup> *Lundberg v. Bayview Hosp.*, note 10 *supra*.

<sup>58</sup> *Id.* at 136, 191 N.E.2d at 823.

<sup>59</sup> 45 Cal. 2d 811, 291 P.2d 915 (1955).



the principal intentionally, or by want of ordinary care, causes a third person to believe to be his agent who is not really employed by him.'"<sup>60</sup>

Again the key factor is apparently some kind of public representation. And yet the indicia of agency are exceedingly weak and involve factors which in the ordinary course of events are not made known to patients. For instance, consider that the anesthesiologist enjoyed staff privileges at only one hospital; that the drugs and equipment he used were supplied by the hospital; that he made himself available for emergency cases on certain regular nights and weekends; and that he was assigned to his case by the operating room supervisor who was an employee of the hospital. These reflect nothing more than some of the privileges and duties of staff membership, yet the court held that this was sufficient to establish a *prima facie* case of agency since there was nothing in the record to show that the plaintiff should have been on notice that the anesthesiologist was not an employee of the hospital. This is a strange conclusion in view of the fact that only a small minority of physicians are salaried employees of hospitals. A more reasonable view would be to consider the more probable relationship (independent contractor) to be the fact. The hospital did not bill the patient for his services, and in view of the common knowledge that physicians frequently refer their patients to other doctors for special services, a more reasonable inference would have been that her surgeon had requested the services of the anesthesiologist and that he, like her surgeon, was an independent contractor. There may be some social justification for the outcome of this case, but there is surely little basis in precedent.

Another troublesome aspect pervading these cases is that courts have repeatedly stated that the corporate practice of medicine is illegal. Such of these decisions as involve hospitals have generally been rendered with respect to the sciences of radiology and pathology. In malpractice cases, however, a close scrutiny of the relationship between the hospital and its medical staff is necessary in order to determine the applicability of the doctrine of *respondeat superior*. If the tortfeasor is found to be an independent contractor and the hospital to be immune from liability, the statement is frequently made that a hospital is a corporation and cannot practice medicine.<sup>61</sup> If, on the other hand, the physi-

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<sup>60</sup> *Id.* at 831, 291 P.2d at 927.

<sup>61</sup> See, e.g., *Moon v. Mercy Hosp.*, 150 Colo., 430, 433, 373 P.2d 944, 945 (1962): "That a hospital employs doctors on its staff does not make it liable for the discharge of their professional duty since it is powerless, under the law, to command or forbid any act by them in the practice of their profession." However, hospitals do make

cian, intern, or resident is found to be a salaried employee, liability is imputed, presumably on the basis of "right to control," giving rise to an inference that the hospital is legally required to furnish medical services.<sup>62</sup>

The reconciliation of professional freedom with organizational control, though troublesome at times, presents basically no different problems from the employment of professional personnel in any large organization, public or private, which is managed by laymen. . . . All the more reason is there, when the parties are in agreement and the patient is well served, that the law should not intervene to disrupt a satisfactory relationship.<sup>63</sup>

Apparently some courts are struggling to do just that. In *Lundberg*, the court speaks of the "hospital-patient" relationship with respect to the running of the statute of limitations, while categorically stating that no claim has been made nor evidence presented to charge that the hospital is engaged in the corporate practice of medicine. Such inconsistencies should be resolved before the theory of a "hospital-patient" relationship is made the basis of decision.

The future course of the legal remedies available for injuries induced by medical malpractice remains unsettled, but certain aspects of the problems involved should be objectively weighed. The patient has a right to expect that his doctor will use his best medical judgment when caring for him, uninfluenced by adverse judgments. The client has a right to be fairly compensated when he has been negligently injured. However, courts would do well to consider that intimidated physicians cannot do work of the quality expected of them, and outrageously large judgments cannot help but encourage others to try their luck, particularly when the investment in a lawsuit on a contingent-fee basis is so small.

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rules and regulations regarding medical care to which the doctor must adhere if he wishes to maintain staff privileges.

<sup>62</sup> See, *e.g.*, *Hollant v. North Shore Hosp., Inc.*, 24 Misc. 2d 892, 206 N.Y.S.2d 177 (1960). The court argued that if a resident staff doctor, in compliance with an order of an independent surgeon, should place the patient in jeopardy, the hospital would be liable, provided that in following the order, the resident was within the course of his employment with the hospital.

<sup>63</sup> Willcox, *Hospitals And The Corporate Practice Of Medicine* 3 (1957).